

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2023
NAME OF PROVIDER OR SUPPLIER PREFERRED CARE AT ABSECON			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 PITNEY ROAD ABSECON, NJ 08201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 09/25/23 to 09/28/23 Survey Census: 150 Sample Size: 30 Supplemental Residents: 0 COMPLAINT #s: Intake NJ159494: Unsubstantiated with no cites. Intake NJ160430: Unsubstantiated with no cites. Intake NJ161143: Unsubstantiated with no cites. Intake NJ164242: Substantiated with a deficiency at F584 Intake NJ165369: Unsubstantiated with no cites. Intake NJ167015: Substantiated with a deficiency at F600. Intake NJ167039: Unsubstantiated with no cites. Intake NJ167057: Unsubstantiated with no cites. Intake NJ167175: Unsubstantiated with no cites.	F 000			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584		10/23/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/19/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	<p>Continued From page 1 possible.</p> <p>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ164242</p> <p>Based on observation, interview, and policy review, the facility failed to provide a clean and sanitary environment for one of six residents (Resident (R)14) reviewed room disrepair out of a total sample of 33 residents.</p>	F 584	<p>Element #1 – Resident R 14 room, walls and areas of the room were immediately cleaned. The privacy curtain was taken down and replaced. Sheets and linens were removed and replaced on 9/27/23. The maintenance department repaired all cracks and holes on 10/11/23.</p>		

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F 584	<p>Continued From page 2</p> <p>On 09/25/23 at 3:33 PM, an interview was attempted with R14. She NJ Exec. Order 26:4.b.1 to questions asked about her room.</p> <p>During an interview on 09/26/23 at 10:15 AM, family Member (FM)25 was asked about R14's room. FM25 stated, Ex Order 26. 4B1 [REDACTED]</p> <p>During an observation on 09/27/23 at 11:57 AM, R14's room revealed a patch of white was seen on the wall next to the bathroom door at eye level. From the doorway brown colored stains on the privacy curtains could be seen. Walking into the room revealed plaster was missing around the air conditioning unit exposing holes and cracks along with a dark substance was seen on the wall. Near the baseboard on the wall was a hole. In the corner behind the bed was a brown colored stain and the floor behind the bed also was stained. The wall where the television was located also had a brown colored stain. Two holes in the bed linen were also noted on the right top corner of the resident's bed.</p> <p>During an interview on 09/28/23 at 8:25 AM, the Maintenance Director (MD) was shown the room and the concerns that were found. The MD confirmed the concerns and was asked if he had noticed them. The MD stated, "I do checks when I walk around the building. Staff can also let me know if there are concerns and report them in the system. Everything is planned to be remodeled,</p>	F 584	<p>Element #2 - All residents rooms have the potential to be affected by this practice.</p> <p>Element #3 –</p> <ol style="list-style-type: none"> 1. Deep cleaning schedule for resident rooms was reviewed and revised as needed. Housekeepers were re-in-serviced on the new schedule and were re-educated on cleaning rooms including hard to reach area on a daily or as needed basis. The education was conducted on 9/29/23. These in-services will be given during orientation for newly hired housekeeping staff, annually and as deemed necessary. 2. The cleaning schedule for resident rooms was reviewed and revised as needed. Housekeepers were re-in-serviced on the new schedule and were re-educated on cleaning rooms including hard to reach area on a daily or as needed basis. The education was conducted on 9/29/23. These in-services will be given during orientation for newly hired housekeeping staff, annually and as deemed necessary. 3. Room cleaning schedules are now logged in the house keeping logbook/sheets. 4. The maintenance department logs all environmental repairs that were completed in the maintenance log. 5. The maintenance department logs all environmental repairs that were completed in the maintenance log. <p>Element #4 – Weekly environmental audits of 5 rooms</p>		

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F 584	<p>Continued From page 3</p> <p>but I do not know when that is, but the room should not look like this."</p> <p>During an interview on 09/28/23 at 8:39 AM, the Director of Housekeeping (DOH) was asked about the curtains and the stains on the floor and walls. The DOH stated, "I don't know what happened that the curtains, floor and walls look like this. They should not look like this. The curtains should have been taken down and replaced with clean ones. The staff should be cleaning the walls and floors better than this." The DOH was asked about the sheets with the holes. He stated, "staff should be looking at the sheets in laundry when they are washing them, but the CNAs [Certified Nursing Aides] should also report them."</p> <p>During an interview on 09/28/23 at 3:43 PM, the Administrator was asked what his expectations were in regard to the upkeep of the building and the cleanliness. The Administrator stated, "Something like that should be one's right [for comfortable, clean room]. We want everyone to be comfortable."</p> <p>Review of the facility policy titled "Quality of Life-Home Like Environment," with a revised date of 10/2022, revealed "Policy statement: Residents are provided with a safe, clean and comfortable environment. . . Policy Interpretation. . . 2. The facility staff management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized home-like setting. These characteristics include a) Cleanliness and order. . ."</p> <p>Review of the facility policy titled "Routine Cleaning and Disinfection," with a revised dated</p>	F 584	<p>across all units x 4 weeks and then monthly x 3 months will be conducted by the Director of Housekeeping to ensure that Deep cleaning of residents rooms is properly cleaned</p> <p>Weekly environmental audits of 5 rooms across all units x 4 weeks and then monthly x 3 months will be conducted by the Director of Maintenance to ensure that necessary environmental repairs are completed and logged</p> <p>Any negative findings will be corrected immediately through one-on-one re-educations and disciplinary measures as appropriate.</p> <p>Results of all audits will be reported to the QAA committee by the Housekeeping Director who meets quarterly and will determine the necessity of future audits and recommendations.</p>		

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F 584	Continued From page 4 of 11/2022, revealed, "Policy: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. . . 13. Cleaning of walls, blinds and window curtains will be conducted when visibly soiled. 14. Privacy curtains in resident rooms will be changed when visibly dirty by laundering or cleaning with an EPA [Environmental Protection Agency] . . . "	F 584			
F 600 SS=D	NJAC 8:39-4.1(a)11 NJAC 8:39-31.2(e) NJAC 8:39-31.4(a)(f) Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: COMPLAINT# NJ167015 Based on observation, interview, record review,	F 600	E-#1 CNA4, RN18 and UM20 were re-in serviced on 10/12/23 regarding resident	10/23/23	

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F 600	<p>Continued From page 5</p> <p>and policy review, the facility failed to protect a resident's right to be free of physical abuse for one of (Resident (R)72) of seven residents reviewed for abuse out of a total sample of 33 residents.</p> <p>Findings include:</p> <p>1. Review of R72's Admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of [redacted], located in the "MDS" tab of the electronic medical record (EMR), revealed an admission date of [redacted], a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15 indicating <i>Ex Order 26. 4B1</i></p> <p>[redacted]. These [redacted] were documented as not interfering with other residents' care.</p> <p>Review of R72's [redacted] care plan, located in the EMR under the "Care Plan" tab, revealed R72 "Has [redacted] at times."</p> <p>Review of R72's nurse notes [redacted] to [redacted], located under the "Progress Notes" tab, revealed R72 did [redacted] with other residents at the facility.</p> <p>Review of R72's [redacted] incident notes, located in the EMR under the "Progress Notes" tab, revealed "R72 went into the dining room and sat at the same table as another resident. Another resident who was sitting at the table hit [R72] in</p>	F 600	<p>#79 specific instructions in accordance with resident individualized plan of care in dealing with <i>Ex.Order 26.4(b)(1)</i>.</p> <p>E-2 All residents with reported incidents of resident-to-resident altercations have the potential to be affected by this practice.</p> <p>E-3 1. Facility Nursing Management were re-educated regarding the facility's processes in communicating to nursing staff specific instructions and or interventions following an incident of resident-to-resident altercations to assure that the staff are aware of the specific interventions, and they are implemented. This Inservice education was initiated on 10/12/23 and ongoing and during orientation for a newly hired Nurse Supervisor/Nurse Management, and as deemed necessary.</p> <p>2. Licensed staff nurses and CNAs were re-educated on 10/12/23 and ongoing regarding the facility's processes of communication regarding specific interventions and or instructions following an incident of resident-to-resident altercations to assure awareness of specific intervention and implementations. This in-service will be given during the orientation of a newly hired nursing staff, annually and as deemed necessary.</p> <p>E-4 1. The Director Of Nursing and or nurse designee will conduct weekly audits of 5 nursing staff across all shifts for residents</p>		

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F 600	<p>Continued From page 6</p> <p>the face. Residents immediately separated and kept separated. Complete head-to-toe assessment- completed, acquired ^{Ex Order 26.4B1} under ^{Ex Order 26.4B1} 1cm [centimeter] in length and ^{NJ Exec. Order 26:4.b.1} and around the ^{NJ Exec. Order 26:4.b.1}, the ^{NJ Exec. Order 26:4.b.1} the ^{Ex Order 26.4B1} ^{NJ Exec. Order 26:4.b.1} from ^{Ex Order 26.4B1} ^{NJ Exec. Order 26:4.b.1}. Family, MD [physician], DON [Director of Nursing], admin [Administrator], UM [unit manager], AND ^{Ex Order 26.4B1} [name] were made aware. ^{Ex Order 26.4B1} was cleansed with ^{Ex Order 26.4B1} and left open to the air, and no ^{NJ Exec. Order 26:4.b.1} was noted. ^{Ex Order 26.4B1}. The family doesn't want to involve the Police."</p> <p>On 09/25/23 at 2:15 PM, R72 was observed at the end of her hall dressed and groomed and ambulating with a walker.</p> <p>2. Review of R79's quarterly "MDS" with an ARD date of ^{NJ Exec. Order 26:4.b.1}, located in the EMR under the "MDS" tab revealed an admission date of ^{NJ Exec. Order 26:4.b.1}, a "BIMS" score of ^{Ex Order 26.4B1} out of 15 indicating R79's cognition was ^{Ex Order 26.4B1}, had a diagnosis of ^{Ex Order 26.4B1}, and had ^{NJ Exec. Order 26:4.b.1} of ^{Ex Order 26.4B1}.</p> <p>Review of R79's ^{NJ Exec. Order 26:4.b.1} care plan, located under the "Care Plan" tab in the EMR, revealed R79 "Has ^{NJ Exec. Order 26:4.b.1}, can be ^{NJ Exec. Order 26:4.b.1} at times ... r/t [related to] ^{Ex Order 26.4B1}."</p> <p>Review of R79's ^{NJ Exec. Order 26:4.b.1} notes, dated ^{NJ Exec. Order 26:4.b.1} to ^{NJ Exec. Order 26:4.b.1} and located under the "Progress Notes" tab, revealed R79 did not have prior incidents of ^{Ex Order 26.4B1} at the facility.</p>	F 600	<p>with a reported incidents of resident-to-resident altercations to assure that staff are aware of the specific instructions and intervention are being implemented x 4 weeks and then monthly for 3 months. Any negative findings will be corrected through one-on-one education and disciplinary actions as appropriate.</p> <p>2. The results of the audits will be submitted by the Director Of Nursing to the QAA committee who meets quarterly to determine the necessity of future audits and recommendations.</p>		

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F 600	<p>Continued From page 7</p> <p>On 09/25/23 at 2:25 PM, R79 was observed sitting in the lobby dressed and groomed watching television with other residents sitting in and around her. R72 was not observed in the immediate area.</p> <p>During an interview on 09/26/23 at 9:44 AM, R79 denied any problems with other residents and any Ex Order 26. 4B1.</p> <p>During an interview on 09/26/23 at 12:46 PM, Certified Nurse Aide (CNA)4 was asked about R79's NJ Exec. Order 26.4.b.1. CNA4 stated she's worked at the facility for four months. CNA4 was asked if R79 had any problems with other residents such as hitting, and she said "no."</p> <p>During an interview on 09/26/23 at 4:55 PM, Registered Nurse (RN)18 was asked if R79 had any special instructions staff should follow. RN18 stated "no." RN18 was asked if R79's had abusive behavior toward other residents. RN18 stated she'd worked at the facility for four years and never known R79 to be abusive towards other residents as R79 keeps to herself. RN18 went on to say if R79 gets upset she may throw a Ex Order 26. 4B1 but does NJ Exec. Order 26.4.</p> <p>During an interview on 09/27/23 at 9:29 AM, RN17 was asked about R79's NJ Exec. Order 26.4.b.1. RN17 stated she was on duty 08/27/23, the day of the incident. RN17 stated they keep the residents [R79 and R72] separated. RN17 stated R79 isn't the type typically to hit someone as she keeps to herself and is very mild mannered.</p> <p>During an interview on 09/28/23 at 9:24 AM, Unit Manager (UM)20 was asked about R72 and R79's Ex Order 26. 4B1 Ex Order 26. 4B1. UM20 stated it was an</p>	F 600			

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F 600	Continued From page 8 isolated incident. UM20 went on to say both residents just happened to sit next to each other, and now staff know to ensure R72 and R79 don't interact with each other. UM20 stated, "no incident has occurred before or since then." Review of the facility investigation, dated [redacted] revealed "On [redacted], [R79] was sitting in the dining room; [R72] came and sat down at the same table. Suddenly, [R79] [R72] in the [redacted]. Residents were immediately separated and kept separated- a [redacted] was completed on both residents. [R79] was placed on 1:1 and sent to [hospital]." "Conclusion: Abuse and neglect have been ruled out. Based on the investigation, the incident was isolated and unavoidable and related to [redacted] and the inability of the resident to deal with the [redacted] There was no motive and intention to hurt another patient but rather the [redacted] to deal with one's [redacted]" Review of the policy titled, "Abuse, neglect, exploration, mistreatment and misappropriation of resident property," dated 11/03/22, revealed "The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves ... D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect."	F 600			
F 656 SS=G	NJAC 8:39-4.1(a)5 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		10/23/23	

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F 656	Continued From page 9 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656			

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F 656	Continued From page 10 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 656	<p>Element 1:</p> <p>1. Resident # 30 air mattress was evaluated to assure it was set at the correct firmness for the resident's weight and pressure relief according to manufacturer's directions. Nursing staff that were involved with the resident's care were re-educated regarding ^{Ex Order 26. 4B1} interventions such as application of ^{Ex Order 26. 4B1}, repositioning every 2 hours, appropriate setting of air mattress and accurate documentation in the resident's medical record. This was completed on 9/27/23.</p> <p>Element 2:</p> <p>1. All residents who have a documented pressure injury have the potential to be affected by these practices.</p> <p>Element 3:</p> <p>1. Re-education with License nurses, CNA's regarding pressure relief interventions such as application of heel pads, repositioning every 2 hours, appropriate setting of air mattresses and accurate documentations in the resident's medical record were initiated on 10/12/13 and ongoing. The in-service will be given during orientation for newly</p>		

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F 656	Continued From page 11	F 656	<p>hired licensed nurses and certified nursing assistants, annually and as deemed necessary.</p> <p>2. Pressure relieving mattresses were labeled with the resident's weight as a guidance for nursing staff in setting the pressure relief mattresses.</p> <p>3. Residents who require every 2 hours repositioning and heel pads are noted in the CNA tasks</p> <p>4. Review and revision of facility's Pressure Prevention policy was completed on 10/12/23. Nursing Staff were re-in-serviced with the updated policy.</p> <p>Element 4:</p> <p>1. The DON and or nurse designee will conduct a weekly audit for 10 residents x 4 weeks and then monthly x 6 months covering all shifts for residents requiring pressure relief interventions such as air mattresses; heel booties, turning and positioning, to ensure that the air mattresses/pressure relief mattress is set to a desired weight and pressure relief, heel booties are properly placed and turning and positioning in completed. Negative findings will be corrected immediately through one-on-one re-education and or disciplinary measures as appropriate.</p> <p>2. The DON and or designee will conduct weekly documentation audit for 10 residents x 4 weeks and then monthly x 6 months covering all shifts to ensure that documentations are accurate in residents medical record in accordance with the observations of pressure relief</p>		

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F 656	Continued From page 12	F 656	interventions. Negative findings will be corrected immediately through one-on-one re-education and or disciplinary measures as appropriate. 3. Results of the audits will be submitted by the DON to the QAA committee who meets quarterly for review and recommendations.		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and policy review, the facility failed to ensure the staff assessed the resident, notified the nursing supervisor, and/or complete an incident report to determine the cause of a fall for one of three (Resident (R)46) residents reviewed for falls out of a total sample of 33 residents. This deficient practice increased the potential for additional falls to not be reported and/or investigated thoroughly. Findings include: Review of R46's electronic medical record (EMR) revealed an "Admission Record" under the "Profile" tab which indicated R46 was admitted to the facility on <u>Ex Order 26. 4B1</u> with diagnoses of <u>Ex Order 26. 4B1</u> .	F 689	E-1 LPN 12 is no longer an employee at the facility. An incident report was completed for the <u>Ex Order 26.4(b)(1)</u> by Resident #46 to determine the cause of <u>Ex Order 26.4(b)</u> and the care plan was reviewed and updated as needed on 8/31/23. Staff that provide care to Resident #46 received re-education 8/31/23. E-2 All residents that have a fall incident have the potential to be affected by the cited practice. E-3 1. Re-education for licensed nurses was	10/23/23	

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F 689	<p>Continued From page 13</p> <p>Review of R46's EMR revealed a quarterly "Minimum Data Set (MDS)" assessment located under the "MDS" tab. The Assessment Reference Date (ARD) was [redacted] NJ Exec. Order 26:4.b.1. The "MDS" revealed R46 had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15 indicating [redacted] abilities. R46 was also assessed with [redacted] Ex Order 26. 4B1 and required supervision for her [redacted] Ex Order 26. 4B1.</p> <p>Review of R46's EMR revealed a "Progress Note," located under the "Progress Notes" tab and dated [redacted] NJ Exec. Order 26:4.b.1 at 3:51 PM, noting a late entry for [redacted] NJ Exec. Order 26:4.b.1 at 10:38 PM, ". . .Resident [redacted] NJ Exec. O and reach out with her [redacted] Ex Order 26. 4B1. Nurse reach out to break her [redacted] then the resident pulls back, sat herself on the floor. . .Resident was [redacted] NJ Exec. Order 26:4.b.1 [redacted].</p> <p>Review of R46's EMR "Progress Notes," from [redacted] NJ Exec. Order 26:4.b.1 revealed no documentation of any [redacted] NJ Exec. Order 26:4.b.1 after the [redacted] Ex Order 26:4.b.1 on [redacted] NJ Exec. Order 26:4.b.1.</p> <p>Review of R46's EMR revealed a "Progress Note," located under the "Progress Notes" tab and dated [redacted] NJ Exec. Order 26:4.b.1 at 1:31 PM, "Resident was visiting with [family member] reported that her [redacted] Ex Order 26. 4B1 was [redacted] NJ Exec. Order 26:4.b.1 [redacted] . . ." [redacted] Ex Order 26. 4B1 was ordered. [redacted] Ex Order 26. 4B1 revealed a [redacted] Ex Order 26. 4B1 of the [redacted] Ex Order 26. 4B1.</p> <p>On 09/27/23 at 1:06 PM, an interview was attempted with R46. She was asked what happened to her [redacted] in [redacted] NJ Exec. Order 26:4.b.1. R46 stated, "[redacted] Ex Order 26. 4B1"</p>	F 689	<p>initiated on 8/31; 9/1; 10/12/23 and ongoing regarding facility's policy and procedures on Incident and Accident Reporting, Completing and Incident Report, Resident Management post Fall Incident. These in-services will be given during orientation of a newly hired license nurse, annually and as deemed necessary.</p> <p>2. The nursing 24-hour report is being reviewed during the clinical meeting for any resident that had a fall incident to ensure that a Fall incident is completed, staff assessed, and investigation is conducted to assure that interventions is developed and implemented to minimize the potential for additional falls. Negative findings will be corrected through one-on-one re-education and disciplinary measures as appropriate.</p> <p>E-4</p> <p>3. The DON and or nurse designee will conduct a weekly audit x 4 and then monthly x 3 months for resident who has fall incident to assure that a Fall Incident is completed, assessed and investigation is completed. Negative results will be corrected through one-on-one re-education and disciplinary measures as appropriate.</p> <p>4. The results of the audits will be reported by the DON at the QAA committee that meets quarterly and will determine the necessity of future audits and recommendations.</p>		

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F 689	Continued From page 14 During an interview on 09/27/23 at 2:01 PM, Licensed Practical Nurse (LPN)12 was asked what happened. LPN12 stated on [redacted] at almost shift change, the resident came out of her room and started telling everyone to leave because the children were coming. LPN12 further stated that R46 was [redacted], and she was feeling her way around and was touching other residents on the head. "I was trying to redirect her and she became [redacted]. She [redacted], and I reached out for her and she [redacted]. She just sat on the floor. She said she was fine, and she said she had [redacted]. LPN12 was asked why she delayed in writing the note in the EMR and why she did not do an incident report. LPN12 stated, "There were no supervisors working that evening and I did not do an incident report. The resident kept saying she was [redacted]." During an interview on 09/27/23 at 2:31 PM, the Director of Nursing (DON) was asked about the incident. The DON stated, "The resident's [family member] came out and stated that [R46] was complaining of [redacted] hurting and said that she had [redacted]. We immediately assessed her and got [redacted]. We asked her when she [redacted] and she stated it was over the weekend. I spoke with the nurse. She did not do an incident report and she did not tell us about it." The DON was asked what the protocol was when a resident [redacted]. The DON stated the resident should be assessed and an incident report submitted for investigation. The nurse should have notified the supervisor because the Assistant Director of Nursing (ADON) and a Unit Manager were both here that evening. The LPN did not follow protocol." During an interview on 09/27/23 at 3:05 PM, the	F 689			

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F 689	Continued From page 15 ADON was asked about R46's ^{Ex Ord} [REDACTED] . "On ^{NJ Exec. Order 26-4.5.1} [REDACTED] , the nurse upstairs stated that R46's [family member] came out and said that [R46] had reported a ^{Ex Ord} [REDACTED] and ^{Ex Order 26. 4B1} [REDACTED] hurts. The LPN should have said something and filled out an incident report. I did work on ^{NJ Exec. Order 26-4.5.1} [REDACTED] and she could have called me up at the time of the incident." Review of the facility policy titled, "Fall Policy," with a revised date of 11/2022, revealed, "Policy: to provide a system whereby residents falls are reported, their causes identified when possible, and timely interventions are established to reduce the probability of repeated incidents. . . Procedure: 1. A resident sustained a fall (or other incident which can potentially result in an injury), an Incident Report is completed by the nurse who first witnessed the incident. . . 4. The incident will be included in the 24- hour report and monitoring and documentation. . ."	F 689			
F 690 SS=D	NJAC 8:39-27.1(a) Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		10/23/23	

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F 690	<p>Continued From page 16</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interviews, record review, and review of facility policy, the facility failed to properly secure NJ Exec. Order 26:4.b.1 to prevent harm to the Ex Order 26.4B1 for two of two residents (Residents (R)1 and R18) reviewed for Ex Order 26.4B1 out of a total sample of 33 residents. This failure had the potential to cause reoccurring Ex Order 26.4B1 and/or harm to the Ex Order 26.4B1 if the Ex Order 26.4B1 becomes dislodged.</p> <p>Findings include:</p> <p>1. Review of the "Face Sheet" located in R1's electronic medical records (EMR) revealed the</p>	F 690	<p>Element # 1</p> <p>The Ex Order 26.4B1 for Residents 1 and 18 were immediately properly secured on 9/28/23 .</p> <p>Nursing staff were immediately re-educated on the importance of securing Ex Order 26.4B1 to decrease risk for Ex Order or trauma to Ex Order 26.4B1 . Completed on 10/12/23</p> <p>Element #2</p> <p>All residents who have an indwelling catheter have the potential to be affected by this practice.</p>		

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F 690	<p>Continued From page 17</p> <p>resident was admitted to the facility on <u>Ex Order 26. 4B1</u>, with diagnoses that included <u>Ex Order 26. 4B1</u>, <u>Ex Order 26. 4B1</u>, Recurrent Complicated <u>Ex Order 26. 4B1</u>, and <u>Ex Order 26. 4B1</u>.</p> <p>Review of R1's "Care Plan," dated <u>NJ Exec. Order 26.4.b.1</u> and located in the EMR "Care Planning" tab, revealed the resident had a <u>Ex Order 26. 4B1</u> to drainage and to provide <u>Ex Order 26. 4B1</u> care according to facility policy.</p> <p>Review of the R1's "Physician Orders," dated <u>NJ Exec. Order 26.4.b.1</u> and located in the EMR "Orders" tab, revealed the resident was to have <u>Ex Order 26. 4B1</u> per facility policy.</p> <p>Observation on 09/25/23 at 12:58 PM, revealed a <u>NJ Exec. Order 26.4.b.1</u> resident in bed in a private room with a <u>Ex Order 26. 4B1</u> in place, with the <u>Ex Order 26. 4B1</u> hanging to the side of the bed draining <u>NJ Exec. Order 26. 4B1</u> with <u>Ex Order 26. 4B1</u> observed in the tubing and bag. No <u>Ex Order 26. 4B1</u> to the <u>Ex Order 26. 4B1</u> was observed.</p> <p>Observation on 09/26/23 at 12:42 PM, revealed R1 up in a chair with the <u>Ex Order 26. 4B1</u> clipped to the side of the chair. The <u>Ex Order 26. 4B1</u> was not secured to the R1's <u>Ex Order 26. 4B1</u>.</p> <p>Observation on 09/27/23 at 12:25 PM, revealed R1 in bed, with the <u>Ex Order 26. 4B1</u> clipped to the side of the bed with a privacy cover to the bag. The <u>Ex Order 26. 4B1</u> was not secured to R1's <u>Ex Order 26. 4B1</u> with a <u>Ex Order 26. 4B1</u>.</p> <p>2. Review of R18's "Face Sheet" located in R18's EMR revealed the resident was admitted to the facility on <u>Ex Order 26. 4B1</u>, with diagnoses that included <u>Ex Order 26. 4B1</u></p>	F 690	<p>Element #3</p> <ol style="list-style-type: none"> 1. Nursing staff were re-educated on the importance of ensuring that catheter tubing is secured to decrease risk for UTI or trauma to bladder. This education will be given during orientation for a newly hired license nurse or Certified CNA, annually and as deemed necessary. 2. IP nurse and or nurse designee will review residents with new physician order for indwelling catheter during the clinical meeting to ensure that the catheter tubing is properly secured. Negative results will be corrected immediately through one-on-one re-education. The result of the findings will be reported to the DON. <p>Element # 4</p> <p>Facility Infection Preventionist (IP) and or nurse designee will complete a weekly observation audit for all residents in facility with indwelling catheters x 4 weeks and then monthly x 3 months to ensure that indwelling catheters have a securement device in place. Negative results will be corrected immediately through re-education and or disciplinary action as appropriate.</p> <p>Results of the audits will be submitted by the IP to the QAA committee that meets quarterly for review and to determine the frequency and necessity of future audits and actions taken.</p>		

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F 690	<p>Continued From page 18</p> <p>Review of R18's "Care Plan," dated ^{NJ Exec. Order 26:4.b.1} and located in the resident's EMR "Care Planning" tab, revealed the resident had a ^{Ex Order 26. 4B1} to drainage with a goal to remain free from ^{Ex Order 26. 4B1} related ^{NJ Exec. Order 26:4.b.1}.</p> <p>Review of the R18's "Physician Orders," dated ^{NJ Exec. Order 26:4.b.1} and located in the EMR section titled "Orders," revealed the resident was to have ^{Ex Order 26. 4B1} per facility policy.</p> <p>Review of R18's "Orders" section of the EMR revealed an order for monthly ^{Ex Order 26. 4B1} change on the second day of the month.</p> <p>Observation on 09/26/23 at 9:58 AM, revealed R18 in his room up in a chair, with the ^{Ex Order 26. 4B1} clipped to the side of the chair with a ^{Ex Order 26. 4B1} covering the ^{Ex Order 26. 4B1}, draining slightly ^{NJ Exec. Order 26:4.b.1} ^{Ex Order 26.} with ^{NJ Exec. Order 26:4.b.1} in the tubing. R18 had on pants and a ^{Ex Order 26. 4B1} was not visible at that time.</p> <p>Observation and interview on 09/27/23 at 10:57 AM, revealed R18 in bed. Licensed Practical Nurse, (LPN) 22 came to the bedside in R18's room. LPN22 observed with the surveyor that R18's ^{Ex Order 26. 4B1} was on the ^{Ex Order 26. 4B1} of the top of the bed with no ^{Ex Order 26. 4B1} or ^{Ex Order 26. 4B1} to cover the bag. The ^{Ex Order 26. 4B1} was hanging clipped on the opposite side of the bed. The ^{Ex Order 26.} was very ^{NJ Exec. Order 26:4.b.1} color with ^{NJ Exec. Order 26:4.b.1} in the tubing. The ^{Ex Order 26. 4B1} appeared to be almost full. Interview with the LPN22 revealed that the bag needed to be emptied and covered with the ^{Ex Order 26. 4B1}, but the LPN22 did not apply any ^{Ex Order 26. 4B1} to the tubing after emptying the bag.</p> <p>Interview on 09/27/23 at 3:39 PM, with Unit</p>	F 690			

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F 690	Continued From page 19 Manager (UM) 21, revealed that Ex Order 26. 4B1 should be used for residents with a Ex Order 26. 4B1 . UM21 observed that R1 and R18 did not have a Ex Order 26. 4B1 in place. Interview on 09/28/23 at 9:20 AM, with Certified Nursing Assistant, (CNA)23, verified that R1 and R18 did not have a Ex Order 26. 4B1 for the Ex Order 26. 4B1 . CNA23 stated that Ex Order 26. 4B1 were used only for ambulatory residents. Interview on 09/28/23 at 4:00 PM, with the DON, revealed that Ex Order 26. 4B1 were provided in the Ex Order 26. 4B1 and should be applied to the residents and changed as needed for protection. Review of the facility's undated policy titled, Ex Order 26. 4B1 " reads in part "Change the Ex Order 26. 4B1 and Ex Order 26. 4B1 when necessary . . . Ex Order 26. 4B1 should be properly secured to prevent movement and Ex Order 26. 4B1 . . . Keep the Ex Order 26. 4B1 below the level of the Ex Order 26. 4B1 . . . "	F 690			
F 692 SS=D	NJAC 8:39-19.4(a)5 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or	F 692		10/23/23	

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F 692	<p>Continued From page 20</p> <p>desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interview, record review, and policy review, the facility failed to provide prescribed nutrition interventions to address significant weight loss for one (Resident (R)72) of six residents reviewed for nutritional status out of a total sample of 33 residents.</p> <p>Findings include:</p> <p>Review of R72's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of [redacted], located in the "MDS" tab of the electronic medical record (EMR), revealed an admission date of [redacted], a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15 indicating [redacted], had diagnoses of [redacted].</p> <p>Review of R72's revised [redacted] care plan located in the EMR under the "Care Plan" tab</p>	F 692	<p>Element #1 – Resident R 72 was immediately re-evaluated by the Registered Dietitian (RD) on 9/27/23 and provided with [redacted] food as recommended by the RD.</p> <p>Element #2 – All residents with a physician's orders for double portions and fortified food have the potential to be affected by this practice.</p> <p>Element #3 – Dietician reviewed the list of residents that are on fortified diets with the Food Service Director to assure meals are provided as ordered completed 10/16/23 Re- education of the cooks on properly preparing fortified menus and Dietary aides on recognizing and serving orders for double portions by the Food Service Director (FSD) was initiated on 10/12/23 and ongoing. These in-services will be given during orientation for newly hired Cooks and Dietary Aides, annually and as deemed necessary.</p> <p>Element #4 –</p>		

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F 692	<p>Continued From page 21</p> <p>revealed "[R72] Has NJ Exec. Order 26:4.b.1 or potential NJ Exec. Order 26:4.b.1 related to Ex Order 26. 4B1, meal refusals, limited food acceptance, need for appetite stimulant, variable ^{Ex Ord} [oral] intakes, significant weight changes, Ex Order 26. 4B1 for Ex Order 26. 4B1</p> <p>[REDACTED]. An intervention revealed "Provide diet as ordered. Ex Order 26. 4B1, Ex Order 26. 4B1, Ex Order 26. 4B1, thins (Ex Order 26. 4B1) double portions NJ Exec. Order 26:4.b.1," On 09/27/23 the intervention was revised to "double portions per request."</p> <p>Review of R72's NJ Exec. Order 26:4.b.1 diet order located in the EMR under the "Orders" tab revealed Ex Order 26. 4B1, Ex Order 26. 4B1, NJ Exec. Order 26:4.b.1</p> <p>Review of R72's NJ Exec. Order 26:4.b.1 "Nutrition Assessment Quarterly and Weight Change," located in the EMR under the "Progress Note" tab, revealed "Diet: Ex Order 26. 4B1, Ex Order 26. 4B1 thins. Double portions. No straw; NJ Exec. Order 26:4.b.1 ... female triggers for significant, undesirable NJ Exec. Order 26:4.b.1 related to variable ^{Ex Ord} intakes, with need for constant cueing during mealtime and being NJ Exec. Order 26:4.b.1 meal refusals and increased energy needs due to ambulatory energy expenditure on unit, evidenced by NJ Exec. Order 26:4.b.1 months. Ex Order 26. 4B1 is now Ex Order 26. 4B1 lbs - Ex Order 26. 4B1 is Ex Order 26. 4B1 (Ex Order 26. 4B1) ..."</p> <p>Review of R72's weight history, located in the EMR under the "Weight/Vitals" tab, revealed R72 had NJ Exec. Order 26. 4B1 of Ex Order 26. 4B1 body weight in three months.</p>	F 692	<p>Weekly audits for 5 trays across all meals will be conducted by the Food Service Director (FSD) or designee x 4 weeks and monthly x 3 months for meal accuracy to assure that residents with an order for double portions and fortified diets are provided in the resident tray. Any negative findings regarding meal accuracy will be corrected immediately through one-on-one re-education or disciplinary measures as appropriate. The results of the audits will be reported by the FSD at the QAA committee that meets quarterly and will review findings and recommendations.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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F 692	<p>Continued From page 22</p> <p>This included:</p> <p>09/18/23 at ^{Ex Order 26} Lbs [pounds] 08/08/23 at ^{Ex Order 26} Lbs 07/26/23 at ^{Ex Order 26} Lbs 07/17/23 at ^{Ex Order 26} Lbs 07/14/23 at ^{Ex Order 26} Lbs 07/05/23 at ^{Ex Order 26} Lbs 06/22/23 at ^{Ex Order 26} Lbs</p> <p>On 09/26/23 at 12:38 PM, R72 was served her lunch that included ice cream, juice, a regular portion of brussels sprouts, a regular portion of ground beef with gravy, a regular portion of mashed potatoes with gravy. Review of R72's meal ticket revealed a ^{Ex Order 26. 4B1}, thin liquids, double portions."</p> <p>Review of R72's ^{NJ Exec. Order 26-A.6.1} meal intake located in the EMR under the "Task" tab revealed R72 consumed ^{Ex Order 26. 4B1} of her lunch.</p> <p>On 09/27/23 at 11:21 AM, the tray line in the kitchen was observed with gravy, pureed gravy, sweet potatoes, mixed vegetables, pureed mixed vegetables, beef pot pie, mashed potatoes, grilled cheese sandwiches, hot dogs, cheeseburgers, pureed turkey, ground turkey, and pre-sliced turkey. No fortified items or double portion provisions were on the tray line. Dietary Aide (DA)1 was observed serving resident plates with four-ounce scoops and four-ounce ladles. DA1 confirmed these serving utensils and food items on the line at this time.</p> <p>On 09/27/23 at 1:05 PM, R72 was served milk, juice, a regular portion of mashed potatoes, a regular portion of ground turkey, a regular portion of pureed vegetables, and pureed cake. R72's meal ticket revealed a ^{Ex Order 26. 4B1}, thin liquids,</p>	F 692			

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F 692	<p>Continued From page 23</p> <p>double portions." Registered Nurse (RN)17 confirmed R72 received regular serving sizes and confirmed the meal ticket reflected double portions.</p> <p>On 09/27/23 at 3:51 PM, the Registered Dietitian (RD) was asked if she was aware of R72's weight since admission and RD stated "yes." RD was asked if she was aware that double portions were not provided at lunch and double portions and fortified foods were not provided at lunch. RD stated, "sometimes it goes missed by the kitchen." RD stated R72 was also receiving health shakes, magic cups, and an appetite to help with her intake. RD stated R72's intake could vary and agreed R72 was very active on the unit. RD stated once the nurse pointed it out to the kitchen double portions were not on R72's lunch tray, double portions were provided. RD was asked if the nurse should be checking the trays to ensure accuracy of diets and she stated it would be good if they did.</p> <p>On 09/28/23 at 8:08 AM, the Dietary Director (DD) was asked about the for R72 at lunch. DD stated that "it was an oversight" yesterday at lunch, not having a item.</p> <p>On 09/28/23 at 8:13 AM, DA2 was asked about fortified foods. DA2 stated they only have a few residents with a diet. DA2 was asked what a diet was. DA2 stated it was a separate pan of a food item on the tray line that had sugar, powdered milk, and/or butter added to it. DD was present and asked why there wasn't a separate pan yesterday at lunch on the tray line that was fortified. DD stated, "it is a work in</p>	F 692			

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F 692	Continued From page 24 progress." DD pointed to a pan identifying it as hot cereal on the tray line as the [Ex. Order 26.4(b)(1)] item for breakfast the morning of 09/28/23. On 09/28/23 at 8:33 AM, DD confirmed there should have been another pan for the [Ex. Order 26.4(b)(1)] diets on the tray line at lunch on [Ex. Order 26.4(b)(1)]. On 09/28/23 at 9:45 AM, DON was asked about R72's [Ex. Order 26.4(b)(1)]. DON stated R72 was constantly moving and expending a lot of calories on the unit. DON went on to say R72 didn't like the consistency of her food. DON was asked if she was aware R72's diet wasn't [Ex. Order 26.4(b)(1)] as ordered. At 11:22 AM, DON stated she checked with the kitchen, and they told her every resident was [Ex. Order 26.4(b)(1)] yesterday, 09/27/23. Review of the facility's policy titled "Nutrition Weight Loss- Clinical Protocol," revised 09/17, revealed "The physician and staff will monitor nutritional status, an individual's response to interventions,..." Review of the facility's policy titled "Food and Nutrition Services," revised 10/17, revealed "7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, ..." "a. If an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff will report it to the Food Service Manager so that a new food tray can be issued." NJAC 8:39-17.4(a)1,2 NJAC 8:39-27.2(e)	F 692			
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		10/23/23	

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F 804	<p>Continued From page 25</p> <p>§483.60(d) Food and drink Each resident receives and the facility provides-</p> <p>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;</p> <p>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to serve food that was palatable, at the appropriate temperature, and nonrepetitive for five (Resident (R)93, R116, R51, R111, and R187) of seven residents reviewed for food palatability out of a total sample of 33 residents.</p> <p>Findings include:</p> <p>Review of the facility policy titled "Food and Nutrition Services," revised 10/2017, revealed "Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident."</p> <p>Review of the menus for the week of 09/24/23 revealed eggs were planned five out of seven breakfasts and green beans, carrots or a mixture of carrots and green beans were planned six out of 14 lunches and/or dinners.</p> <p>1. Review of R93's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of Ex Order 26.4(b)(1), located in the "MDS" tab of the electronic medical record (EMR), revealed</p>	F 804	<p>E1 Resident R93, R116, R51, R111, and R187) were interviewed by the food service director about their menu preferences on 10/11; 10/16 & 10/18 and noted in the dietary sheets for each resident as appropriate</p> <p>E2 All residents receiving food from the Dietary Service have the potential to be affected by these practices.</p> <p>E3 The Food Service Director will conduct monthly meetings with residents to discuss variations that can be added to the menu. Food preferences and menu changes are discussed at Resident menu committee meetings and recommendations made and implemented as appropriate quarterly. Dietary staff was re- educated on 10/18/23 regarding following the provided recipes and correct serving temperatures of food. This in-service will be given on orientation for a newly hired Dietary staff, annually and as deemed necessary.</p>		

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F 804	<p>Continued From page 26</p> <p>an admission date of ^{Ex Order 26.4B1} [REDACTED], a "Brief Interview for Mental Status (BIMS)" score of ^{Ex Ord} [REDACTED] out of 15 indicating R93's cognition was ^{Ex Order 26.4B1} [REDACTED] and had a diagnosis of ^{Ex Order 26.4B1} [REDACTED].</p> <p>On 09/25/23 at 12:25 PM, R93 was served his lunch in his room on an overbed table that was pushed to the side against the wall. R93's lunch included a chicken breast, rice, mixed vegetables that included green beans, carrots, and a dessert. R93 stated the food wasn't good and he wouldn't be eating his lunch. R93's chicken breast had a dried-out appearance and the mixed vegetables appeared overcooked and soggy. R93 complained of always being served the same thing.</p> <p>On 09/27/23 at 12:20 PM, R93 was served his lunch tray in his room on an overbed table and the food was still covered. R93 opened the lid and his lunch included turkey with gravy, sweet potatoes, mix vegetables that included green beans, carrots, brussels sprouts, and cauliflower, ice cream, and cake. R93 stated the food wasn't good and he wasn't going to eat his lunch saying, "it's always the same thing."</p> <p>2. During an interview on 09/25/23 at 11:03 AM, R116 was asked about the food. R116 stated, "[REDACTED]"</p> <p>Review of R116's electronic medical record (EMR) quarterly "Minimum Data Set (MDS)" assessment located under the "MDS" tab, with an Assessment Reference Date (ARD) of ^{Ex Order 26.4(b)(1)} [REDACTED] revealed a "Brief Interview for Mental Assessment (BIMS)" with a score of ^{Ex Ord} [REDACTED] out of 15 indicating</p>	F 804	E4 Food Service Director/Dietician or designee will sample 5 trays weekly for four weeks and then monthly for 3 months covering all meals to check on the palatability and temperature of the food. 10 Resident surveys will be taken regarding the palatability and temperature of the food weekly times 4 weeks and then monthly times three months. All findings will be reported by the Food Service Director at the QAPI committee that meets quarterly and will determine the necessity of future audits and recommendations.		

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F 804	<p>Continued From page 27</p> <p><i>Ex Order 26. 4B1</i> .</p> <p>Review of R116's EMR physician orders, located under the "Orders" tab, revealed on <i>Ex Order 26.4(b)(1)</i> a <i>Ex Order 26. 4B1</i> with <i>Ex Order 26. 4B1</i> .</p> <p>3. During an interview on 09/25/23 at 3:00 PM, R51 was asked about the food. R51 made a face and stated, <i>Ex Order 26. 4B1</i> ."</p> <p>Review of R51's EMR the quarterly "MDS" assessment located under the "MDS" tab, with an ARD of <i>Ex Order 26.4(b)(1)</i>, revealed a "BIMS" with a score of <i>Ex Ord</i> out of 15 indicating <i>Ex Order 26. 4B1</i> .</p> <p>Review of R51's EMR physician orders, located under the "Orders" tab, revealed on <i>Ex Order 26.4(b)(1)</i> a <i>Ex Order 26. 4B1</i> with <i>Ex Order 26. 4B1</i> .</p> <p>3. During an interview on 09/26/23 at 9:11 AM, R111 was asked about the food. R111 stated, <i>Ex</i> "</p> <p>Review of R111's EMR admission "MDS" assessment located under the "MDS" tab, with an ARD of <i>Ex Order 26.4(b)(1)</i>, revealed a "BIMS" with a score of <i>Ex Ord</i> out of 15 indicating <i>Ex Order 26. 4B1</i> .</p> <p>Review of R111's EMR physician orders, located under the "Orders" tab, revealed on <i>Ex Order 26.4(b)(1)</i> a <i>Ex Order 26. 4B1</i> with <i>Ex Order 26. 4B1</i> .</p> <p>4. During an interview on 09/26/23 at 9:36 AM, R187 was asked about the food. R187 stated,</p>	F 804			

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F 804	<p>Continued From page 28</p> <p><i>Ex Order 26. 4B1</i> [REDACTED].</p> <p>Review of R187's EMR revealed an admission "MDS" assessment located under the "MDS" tab with an ARD of 09/15/23, revealed a "BIMS" of <i>Ex Order 26. 4B1</i> [REDACTED] out of 15 indicating <i>Ex Order 26. 4B1</i> [REDACTED].</p> <p>Review of R187's EMR physician orders, located under the "Orders" tab, revealed on <i>Ex Order 26.4(b)(1)</i> a <i>Ex Order 26. 4B1</i> [REDACTED] and no added salt (NAS) with <i>Ex Order 26. 4B1</i> [REDACTED].</p> <p>On 09/27/23 at 11:05 AM, the tray line was observed with mixed vegetables that included green beans, carrots, brussels sprouts, and cauliflower. Review of the lunch menus revealed green beans had been served on 09/24/23, carrots on 09/25/23, and brussels sprouts 09/26/23.</p> <p>During the confidential resident council interview on 09/27/23 at 1:38 PM, six residents attended. Complaints were voiced about cold food, particularly scrambled eggs, rice, and noodles, and the menus lacked variety. Complaints were also voiced about the food was often too dry and needed more moisture.</p> <p>During an interview on 09/27/23 at 3:43 PM, the Registered Dietitian (RD) was asked how often she talks to the residents about the food. The RD stated, "Everyday. I go to the residents for input. We recently went through a new food service provider. Our goal is to improve the quality and taste of the food. Once we get a food service director, we start working with them and then they leave, and we have to begin again."</p>	F 804			

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F 804	Continued From page 29 On 09/28/23 at 9:01 AM, a test tray was sampled with the Dietary Director (DD). The tray included scrambled eggs, cubed potatoes, cream of wheat, milk, and juice. The scrambled eggs were noted to be dry and in hard clumps and the cream of wheat was very soupy. During an interview on 09/28/23 at 9:08 AM, DD agreed the cream of wheat was too liquid and stated, "the residents think the eggs are powdered." DD was asked about the repeat of food items on the menu such as poultry, eggs and vegetables. DM stated he was aware of the repetitive menu items. NJAC 8:39-17.4(a)2	F 804			

New Jersey Department of Health

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on facility document review it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:	S 560	CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The facility actively seeks to hire CNAs, that all shifts are scheduled to comply with ratios, that any callouts or no-shows result in calls being made by the shift supervisor to fill the shift. Facility has documented evidence to reflect facility's Recruitment and Retention Efforts in its relentless attempts to comply with the staffing ratios. No residents have been adversely affected. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE	10/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/19/23

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060115	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/28/2023
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NAME OF PROVIDER OR SUPPLIER PREFERRED CARE AT ABSECON	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 PITNEY ROAD ABSECON, NJ 08201
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	<p>Continued From page 1</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>The facility was deficient in CNA staffing for residents day shifts as follows:</p> <p>1. For the 2 weeks of Complaint staffing from 12/18/2022 to 12/31/2022, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows:</p> <p>-12/18/22 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs. -12/19/22 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs -12/24/22 had 15 CNAs for 135 residents on the day shift, required at least 17 CNAs. -12/25/22 had 11 CNAs for 135 residents on the day shift, required at least 17 CNAs. -12/31/22 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs.</p> <p>2. For the week of Complaint staffing from 02/05/2023 to 02/11/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows:</p> <p>-02/05/23 had 14 CNAs for 150 residents on the day shift, required at least 19 CNAs. -02/06/23 had 17 CNAs for 150 residents on the</p>	S 560	<p>AFFECTED BY THE SAME DEFICIENT PRACTICE</p> <p>¿ All residents have the potential to be affected by this situation.</p> <p>SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR</p> <p>¿ Facility's Recruitment and Retention Strategies and Efforts to comply with the State's Staffing Ratios have been in progress, which include but are not limited to the following:</p> <ul style="list-style-type: none"> o Offer Sign on bonuses to attract staff o Recruitment bonus to encourage referrals from current staff o Offering daily and weekend bonuses to attract overtime or PRN staff shifts o Aggressively running ads in various social media o Flexible shifts and schedules o Increased wages to be well above state minimum o Increased expedience getting staff on board by offering Orientation every week with a schedule utilizing other sister facilities o Working with C.N.A. schools to recruit new grads o Secured contracts with 3 staffing agencies <p>MONITORING OF CORRECTIVE ACTIONS</p> <p>¿ Staffing Coordinator or designee will provide weekly reports to the Director of Nursing and Administrator regarding all efforts made to try to comply with the State's Staffing Ratios. Reports will be submitted to the QAPI Committee monthly X 3 months then quarterly thereafter.</p>	

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S 560	<p>Continued From page 2</p> <p>day shift, required at least 19 CNAs. -02/08/23 had 17 CNAs for 146 residents on the day shift, required at least 18 CNAs. -02/11/23 had 16 CNAs for 143 residents on the day shift, required at least 18 CNAs.</p> <p>3. For the week of Complaint staffing from 05/14/2023 to 05/20/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows:</p> <p>-05/14/23 had 12 CNAs for 149 residents on the day shift, required at least 19 CNAs. -05/15/23 had 16 CNAs for 149 residents on the day shift, required at least 19 CNAs. -05/16/23 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs. -05/17/23 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs. -05/18/23 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs. -05/19/23 had 14 CNAs for 148 residents on the day shift, required at least 18 CNAs. -05/20/23 had 13 CNAs for 147 residents on the day shift, required at least 18 CNAs.</p> <p>4. For the week of Complaint staffing from 07/09/2023 to 07/15/2023, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows:</p> <p>-07/09/23 had 12 CNAs for 146 residents on the day shift, required at least 18 CNAs. -07/10/23 had 17 CNAs for 146 residents on the day shift, required at least 18 CNAs. -07/15/23 had 16 CNAs for 146 residents on the day shift, required at least 18 CNAs.</p> <p>5. For the 2 weeks of staffing prior to survey from 09/10/2023 to 09/23/2023, the facility was</p>	S 560	<p>Director of HR will submit monthly reports to document status of all recruitment efforts. Director of HR will report monthly to the QAPI Committee X 3 months then quarterly thereafter.</p>	

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S 560	<p>Continued From page 3</p> <p>deficient in CNA staffing for residents on 8 of 14 day shifts as follows:</p> <ul style="list-style-type: none"> -09/10/23 had 12 CNAs for 145 residents on the day shift, required at least 18 CNAs. -09/11/23 had 17 CNAs for 144 residents on the day shift, required at least 18 CNAs. -09/13/23 had 16 CNAs for 144 residents on the day shift, required at least 18 CNAs. -09/14/23 had 15 CNAs for 144 residents on the day shift, required at least 18 CNAs. -09/16/23 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs. -09/17/23 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs. -09/18/23 had 15 CNAs for 150 residents on the day shift, required at least 19 CNAs. -09/23/23 had 15 CNAs for 146 residents on the day shift, required at least 18 CNAs. 	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315244	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 11/6/2023	Y3
NAME OF FACILITY PREFERRED CARE AT ABSECON			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 PITNEY ROAD ABSECON, NJ 08201		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584	Correction	ID Prefix F0600	Correction	ID Prefix F0686	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.12(a)(1)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	10/23/2023	LSC	10/23/2023	LSC	10/23/2023
ID Prefix F0689	Correction	ID Prefix F0690	Correction	ID Prefix F0692	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(g)(1)-(3)	Completed
LSC	10/23/2023	LSC	10/23/2023	LSC	10/23/2023
ID Prefix F0804	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/23/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/28/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315244	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 11/6/2023	Y3
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Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.12(a)(1)	Completed	Reg. #	Completed
LSC	10/23/2023	LSC	10/23/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/28/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060115	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/6/2023
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NAME OF FACILITY PREFERRED CARE AT ABSECON	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 PITNEY ROAD ABSECON, NJ 08201
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	10/24/2023	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/28/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315244	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 09/26/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000			
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/26/23 and the facility and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Preferred Care at Absecon is a two-story, Type II protected building that was built in 2010. The facility is divided into ten smoke compartments. The diesel generator powers 100% of the building per the Maintenance Director. The number of occupied beds was 148 out of 162 at the time of the survey.	K 000			
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National	K 345		10/18/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/19/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 345	Continued From page 1 Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure the fire alarm system was tested and maintained in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 9.6.1.3. This deficient practice had the potential to affect all 148 residents. Findings include: An observation on 09/26/23 at 10:23 AM revealed the Fire Alarm Control Panel indicated a supervisory signal and three trouble signals. During an interview at the time of the observation, the Maintenance Director stated the facility was aware of the supervisory and trouble signals and had scheduled a technician to make repairs. The Maintenance Director stated the signals had been active for a few days. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72 .	K 345	#1 A technician from the fire alarm company immediately repaired the fire alarm panel supervisory. #2 All residents have the potential to be affected by this deficient practice. #3 The maintenance staff were reeducated on maintaining and timely repairs of the fire alarm system. #4 The maintenance director will audit the fire alarm panel for any issues weekly times four weeks and then monthly times three months and ensure the panel is functioning properly. All findings will be reported to the monthly QAPI committee.		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		10/19/23	

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K 363	<p>Continued From page 2</p> <p>hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interviews, the facility failed to provide a suitable means for keeping</p>	K 363	<p>1. The doors for resident rooms #202, 415, 417, and 412 were fixed, allowing it to properly latch into the door frame.</p>		

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K 363	Continued From page 3 corridor doors in accordance with NFPA 101 Life Safety Code (2012 Edition), Section 19.3.6.3. This deficient practice had the potential to affect 72 residents. Findings include: An observation on 09/26/23 at 10:12 AM revealed the corridor door to Resident Room 412 did not close and latch in the door frame. An observation on 09/26/23 at 10:13 AM revealed the corridor door to Resident Room 415 did not close and latch in the door frame. An observation on 09/26/23 at 10:14 AM revealed the corridor door to Resident Room 417 did not close and latch in the door frame. An observation on 09/26/23 at 10:59 AM revealed the corridor door to Resident Room 202 did not close and latch in the door frame. During an interview at the time of the observations, the Maintenance Director confirmed the doors were not closing and latching in the door frame and stated he was unaware. NJAC 8:39-31.2(e)	K 363	2. All residents in rooms 202, 412, 415, and 417 have the potential to be affected by this deficient practice. 3. All maintenance staff were reeducated on ensuring that all doors latch properly 4. The maintenance director or designee will audit 5 doors to ensure that they latch properly per week times four weeks and then per month times 3 months. All findings will be reported to the monthly QAPI committee.		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour	K 372		10/19/23	

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K 372	<p>Continued From page 4</p> <p>fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and interviews, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient practice had the potential to affect all 148 residents.</p> <p>Findings include:</p> <p>An observation on 09/26/23 at 10:35 AM of the smoke barrier, located above the corridor smoke doors by Room 207, revealed a four-inch unsealed gap around a group of five wire penetrations.</p> <p>An observation on 09/26/23 at 10:43 AM of the smoke barrier, located in the bathroom inside Room 108, revealed a two-inch unsealed gap along the top of the smoke wall above the ceiling tile.</p> <p>An observation on 09/26/23 at 10:45 AM of the smoke barrier, located inside the Resident</p>	K 372	<p>E1 Approved fire stop was applied around the wires by room 207 and lounge by room 109 and the gaps at the tops of the barrier wall above the ceiling tile in bathroom 108 and bathroom of room 207, sealing off the cracks.</p> <p>E2 All residents in these areas have the potential to be affected.</p> <p>E3 Maintenance staff were re-in serviced on the life safety requirement of not having penetrations in smoke barrier walls.</p> <p>E4 The maintenance director or designee will monitor for penetrations in the smoke barriers weekly times four weeks and then monthly times four months. All findings will be presented in aggregate at the monthly QAPI committee by the Maintenance Director for further action as needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315244	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER PREFERRED CARE AT ABSECON			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 PITNEY ROAD ABSECON, NJ 08201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 372	Continued From page 5 Lounge by Room 109, revealed a three-inch unsealed gap around a wire penetration above the ceiling tile. An observation on 09/26/23 at 11:04 AM of the smoke barrier, located in the bathroom inside Room 207, revealed a three-inch unsealed gap around a conduit penetration above the ceiling tile. During an interview at the time of the observations the Maintenance Director confirmed the unsealed gaps and penetrations and stated he was unaware of them. NJAC 8:39-31.1(c), 31.2(e)	K 372			
K 923 SS=E	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient	K 923		10/19/23	

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K 923	<p>Continued From page 6</p> <p>care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on observation, record review, and interview, the facility failed to ensure oxygen cylinders were separated from combustible or materials by a minimum distance of 1.5 m (5 ft) in accordance with NFPA 99 Health Care Facilities Code (2012 Edition), Sections 11.3.2.3(2) and 11.6.2. 3. This deficient practice had the potential to affect 53 residents.</p> <p>Findings include:</p> <p>An observation on 09/26/23 at 9:55 AM of the Oxygen Storage Room revealed combustible materials were stored within five feet of the oxygen cylinders. The combustible material included toilet paper and cardboard boxes. There were 24 E-cylinders stored inside the Oxygen</p>	K 923	<ol style="list-style-type: none"> 1. The combustible items were immediately moved away from the oxygen cylinders. 2. This has the potential to affect all the 1st floor residents. 3. Maintenance staff and central supply were re-educated on proper oxygen storage. 4. Maintenance director/designee will audit the oxygen room twice a week times four weeks and then monthly times three months to ensure compliance. All findings will be reported to the monthly QAPI committee. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315244	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 09/28/2023
NAME OF PROVIDER OR SUPPLIER PREFERRED CARE AT ABSECON			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 PITNEY ROAD ABSECON, NJ 08201		
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K 923	<p>Continued From page 7 Storage Room.</p> <p>A review of the facility's "Oxygen Safety Plan", dated 01/24/2022, revealed the facility required at least five feet of separation between combustible materials and oxygen cylinders. According to the Administrator, the most recent staff training of the "Oxygen Safety Plan" was conducted in July 2023.</p> <p>During an interview at the time of the observation, the Maintenance Director confirmed the findings and revealed the facility was not aware that combustibles were being stored in the Oxygen Storage Room.</p> <p>NJAC 8:39-31.2(e) NFPA 99</p>	K 923			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315244	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 11/6/2023
NAME OF FACILITY PREFERRED CARE AT ABSECON		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 PITNEY ROAD ABSECON, NJ 08201

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	10/18/2023	LSC K0363	10/19/2023	LSC K0372	10/19/2023
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # NFPA 101	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC K0923	10/19/2023	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 9/28/2023

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO